3/11/10
PoC accepted
B. Owens HFS

PRINTED: 02/10/20
FORM APPROVE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS146S	A. BUILDING _____ B. WING _____	01/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH TRANSITIONAL REHABILITATION	2035 W. CHARLESTON BLVD. LAS VEGAS, NV 89102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
Z 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 1/28/10, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. Complaint #NV00024204 was unsubstantiated. Complaint #NV00024179 was substantiated with a deficiency (See Tag Z 400) A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiency was identified:	Z 000		
Z400 SS=E	NAC 449.74523 Social Services 1. A facility for skilled nursing shall provide medically-related social services that are designed to assist the patients in the facility in enhancing or restoring their ability to function physically, socially and economically. This Regulation is not met as evidenced by: Based on interview and record review, the social	Z400	Z400 The social service director that was Responsible for assisting the patients In the facility to restore their ability To function physically, socially & Economically has been counseled With a final notification that any Further issues or complaints to Provide timely assistance would Result in termination. An additional Social Service Director has been Hired to ensure future compliance With the responsibilities of the Social service Department	02-16-10

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 2-16-10

STATE FORM 6899 DYQT11 If continuation sheet 1

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Z400	Continued From page 1 worker failed to provide timely assistance to obtain a birth certificate and to arrange a meeting with the family and physician for 2 of 4 residents (Residents #2 and #3). Severity: 2 Scope: 2	Z400		